Hematopoietic: Hepatitis C Enrollment Form

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________ DOB: ____________ Gender: ☐ Male ☐ Female
Address: ______________________ City, State, ZIP Code: ______________________
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: ______________________ Alternate Phone: ______________________
Email: ______________________ Last Four of SSN: __________ Primary Language: ______________
Parent/Caregiver/Legal Guardian Name (Last, First): ______________ **Relationship to patient**: ______________________

2 PRESCRIBER INFORMATION

Prescriber's Name: ☐ ______________ ☐ ______________ ☐ ______________ ☐ ______________
State License #: __________ NPI #: __________ DEA #: __________ Address: ______________________
City, State, ZIP Code: ______________________ Group or Hospital: ______________________
Phone: ______________ Fax ______________ Contact Person: ____________ Contact's Phone: ____________

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name: ______________________ Policy Holder's DOB: __________ Relationship to Patient: __________
Medical Insurance: ______________________ Telephone: __________ Policy ID: ____________ Group #: ____________
Prescription Insurance: ______________________ Prescription Plan Telephone: ______________________
Policy ID: ______________________ Group #: ______________ RX BIN #: ____________ RX PCN #: ____________
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# ______________________

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______ Ship to: ☐ Patient ☐ Office ☐ Other: ________

Diagnosis (ICD-10):

☐ D63.8 Anemia in other chronic diseases classified elsewhere ☐ 285.29 Anemia of other chronic disease
☐ Other Code: ______ Description: ______________________

Patient Clinical Information:

Allergies: ______________________ Height: _____in/cm Weight: _____lb/kg

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: __________
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Epogen	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________ ☐ Multi-dose Vial (MDV): Inject ________ mL (_______units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________	Quantity: __________ Refills: __________
☐ Procrit	☐ 2,000 u/mL (SDV) ☐ 3,000 u/mL (SDV) ☐ 4,000 u/mL (SDV) ☐ 10,000 u/mL (SDV) ☐ 10,000 u/mL-2 mL vial (MDV) ☐ 20,000 u/mL-1 mL vial (MDV)	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________ ☐ Multi-dose Vial (MDV): Inject ________ mL (_______units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: __________	Quantity: __________ Refills: __________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** ______________________ **Date:** ________	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** ______________________ **Date:** ______
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ______________	**ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Please Complete Patient and Prescriber Information

Patient Name: ________________________________ Patient DOB: ___________________ Patient Phone: ___________________

Patient Address: ____

Prescriber Name: ______________________________________ Prescriber Phone: _____________________________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Promacta	☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg	☐ _________ mg PO _________ times per day	Quantity: _______ Refills: _________
☐ Retacrit	☐ 2000 u/mL ☐ 3000 u/mL ☐ 4000 u/mL ☐ 10,000 u/mL ☐ 40,000 u/mL	☐ Single-dose Vial (SDV): Inject the entire contents of 1 vial SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: ___________ ☐ Multi-dose Vial (MDV): Inject ________ mL (_______units) SC ☐ Once a Week ☐ 3 Times a Week ☐ Other: ___________	Quantity: _______ Refills: _________

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